		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042499

Facility Name: MCKINLEY COURT

Address: 500 WEST MCKINLEY AVE. (Number) decatur (City) 62526 (Zip Code)

County: MACON

Telephone Number: (217) 875-0020 **Fax #** (217) 875-9434

IDPA ID Number: 36-4121313

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,252	2,691	8,360	16,303	8
9	SNF/PED					9
10	ICF	22,671	10,658	723	34,052	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,923	13,349	9,083	50,355	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.97%

D. How many bed-hold days during this year were paid by Public Aid?
198 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 7,602

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	225,624	25,318	11,959	262,901		262,901	(904)	261,997			1
2	Food Purchase		181,428		181,428		181,428	(1,542)	179,886			2
3	Housekeeping	178,257	38,651		216,908		216,908	174	217,082			3
4	Laundry	90,676	24,356	1,099	116,131		116,131	(375)	115,756			4
5	Heat and Other Utilities			128,483	128,483		128,483		128,483			5
6	Maintenance	48,824	37,881	48,585	135,290		135,290	(3,856)	131,434			6
7	Other (specify):*			13,077	13,077		13,077		13,077			7
8	**TOTAL General Services**	543,381	307,634	203,203	1,054,218		1,054,218	(6,503)	1,047,715			8
	B. Health Care and Programs											
9	Medical Director			28,920	28,920		28,920		28,920			9
10	Nursing and Medical Records	1,443,991	126,081	16,088	1,586,160		1,586,160	(4,750)	1,581,410			10
10a	Therapy	82,066		7,303	89,369		89,369		89,369			10a
11	Activities	105,728	2,283	11,592	119,603		119,603	214	119,817			11
12	Social Services	27,245		2,852	30,097		30,097		30,097			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,659,030	128,364	66,755	1,854,149		1,854,149	(4,536)	1,849,613			16
	C. General Administration											
17	Administrative	63,693		539,304	602,997		602,997	(526,132)	76,865			17
18	Directors Fees											18
19	Professional Services			152,399	152,399		152,399	13,549	165,948			19
20	Dues, Fees, Subscriptions & Promotions			51,036	51,036		51,036	(30,536)	20,500			20
21	Clerical & General Office Expenses	116,415	25,665	64,064	206,144		206,144	106,267	312,411			21
22	Employee Benefits & Payroll Taxes			438,333	438,333		438,333		438,333			22
23	Inservice Training & Education			2,036	2,036		2,036		2,036			23
24	Travel and Seminar			1,360	1,360		1,360	9,868	11,228			24
25	Other Admin. Staff Transportation			4,083	4,083		4,083		4,083			25
26	Insurance-Prop.Liab.Malpractice			146,549	146,549		146,549	55,195	201,744			26
27	Other (specify):*			1,772	1,772		1,772	(1,772)				27
28	**TOTAL General Administration**	180,108	25,665	1,400,936	1,606,709		1,606,709	(373,561)	1,233,148			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,382,519	461,663	1,670,894	4,515,076		4,515,076	(384,600)	4,130,476			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,712	
	REPAIRS & MAINTENANCE		1,247	
			0	11,959
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,099	
			0	1,099
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,830	
	ELECTRICITY		83,702	
	WATER		8,951	
	CABLE TV - LOBBY		0	
			0	128,483
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,119	
	PAINTING & DECORATING		9,437	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,464	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,920	
	FIRE SERVICE		1,645	
			0	
			0	
			0	48,585
7	**OTHER**			
	SCAVENGER		13,077	
	SECURITY SERVICE		0	13,077
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	28,920	28,920

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	945	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	13,943	
			0	
			0	16,088
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		4,276	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		3,027	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	7,303
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		8,740	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,852	
			0	11,592
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,852	
			0	2,852
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	539,304	539,304
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	23,878	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	128,521	
			0	152,399
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	14,508	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,002	
	EMPLOYEE WANT ADS	XIX F	1,861	
	CONTRIBUTIONS	VI 20 XIX F	20	
	DUES & SUBSCRIPTIONS	XIX F	16,030	
	LICENSES & PERMITS	XIX F	1,021	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	9,246	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	348	51,036
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,971	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,680	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		420	
	TELEPHONE		49,199	
	MESSENGER SERVICE		1,794	
			0	64,064

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	177,901	
	UNEMPLOYMENT COMPENSATION	XIX D	27,622	
	WORKERS COMPENSATION INSURANCI	XIX D	61,972	
	HOSPITALIZATION INSURANCE	XIX D	152,615	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,178	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,368	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	10,677	
	CHICAGO HEAD TAX	XIX D	0	438,333
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,036	2,036
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,360	
			0	
			0	1,360
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,083	4,083
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		146,549	146,549
27	**OTHER**			
	BAD DEBTS	VI 24	1,772	
			0	1,772

GRAND TOTAL COLUMN 3 OTHER 1,670,894

MCKINLEY COURT
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2003

TOTAL FOOD PURCHASE	181,428	PATIENT MEALS	151065
LESS SALES TAX	(1,542)	ADD EMPLOYEE MEALS	0
NET FOOD	179,886	TOTAL MEALS/YEAR	151065
TOTAL PATIENT CENSUS	50,355	NET FOOD	179886
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	151065
TOTAL PATIENT MEALS	151065	COST PER MEAL	1.19
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			58,332	58,332		58,332	210,258	268,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,519	96,519		96,519	353,208	449,727			32
33	Real Estate Taxes			74,349	74,349		74,349		74,349			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(560,340)	15,660			34
35	Rent-Equipment & Vehicles			25,092	25,092		25,092	6,602	31,694			35
36	Other (specify):* STORAGE			3,246	3,246		3,246		3,246			36
37	**TOTAL Ownership**			833,538	833,538		833,538	9,728	843,266			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,046	491,481	664,527		664,527		664,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		173,046	573,606	746,652		746,652		746,652			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,382,519	634,709	3,078,038	6,095,266		6,095,266	(374,872)	5,720,394			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,368)	30		9
10	Interest and Other Investment Income	(82,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,542)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,680)	21		18
19	Entertainment	(14,508)	20		19
20	Contributions	(20)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	1,010	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,772)	27		24
25	Fund Raising, Advertising and Promotional	(8,002)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,246)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(23,001)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,926)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(197,946)	PG6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (197,946)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (374,872)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MCKINLEY COURT

ID# 0042499

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (3,121)	6	1
2	VACATION ACCRUAL	(904)	1	2
3	VACATION ACCRUAL	174	3	3
4	VACATION ACCRUAL	(375)	4	4
5	VACATION ACCRUAL	(735)	6	5
6	VACATION ACCRUAL	(14,437)	10	6
7	VACATION ACCRUAL	214	11	7
8	VACATION ACCRUAL	(2,804)	17	8
9	VACATION ACCRUAL	(1,013)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(23,001)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(904)	0	0	0	0	0	0	0	0	0	0	(904)	1
2	Food Purchase	(1,542)	0	0	0	0	0	0	0	0	0	0	(1,542)	2
3	Housekeeping	174	0	0	0	0	0	0	0	0	0	0	174	3
4	Laundry	(375)	0	0	0	0	0	0	0	0	0	0	(375)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,856)	0	0	0	0	0	0	0	0	0	0	(3,856)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,503)	0	0	0	0	0	0	0	0	0	0	(6,503)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(14,437)	9,687	0	0	0	0	0	0	0	0	0	(4,750)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	214	0	0	0	0	0	0	0	0	0	0	214	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(14,223)	9,687	0	0	0	0	0	0	0	0	0	(4,536)	16
	C. General Administration													
17	Administrative	(2,804)	(523,328)	0	0	0	0	0	0	0	0	0	(526,132)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,010	5,789	6,750	0	0	0	0	0	0	0	0	13,549	19
20	Fees, Subscriptions & Promotions	(31,776)	1,240	0	0	0	0	0	0	0	0	0	(30,536)	20
21	Clerical & General Office Expenses	(7,693)	113,960	0	0	0	0	0	0	0	0	0	106,267	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,868	0	0	0	0	0	0	0	0	0	9,868	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,935	50,260	0	0	0	0	0	0	0	0	55,195	26
27	Other (specify):*	(1,772)	0	0	0	0	0	0	0	0	0	0	(1,772)	27
28	TOTAL General Administration	(43,035)	(387,536)	57,010	0	0	0	0	0	0	0	0	(373,561)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,761)	(377,849)	57,010	0	0	0	0	0	0	0	0	(384,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT # 0042499 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,368)	3,124	237,502	0	0	0	0	0	0	0	0	210,258	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(82,797)	0	436,005	0	0	0	0	0	0	0	0	353,208	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	15,660	(576,000)	0	0	0	0	0	0	0	0	(560,340)	34
35	Rent-Equipment & Vehicles	0	6,602	0	0	0	0	0	0	0	0	0	6,602	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(113,165)	25,386	97,507	0	0	0	0	0	0	0	0	9,728	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(176,926)	(352,463)	154,517	0	0	0	0	0	0	0	0	(374,872)	45

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISES, INC.)		CONSULTANT
					MORTON GROVE	
				MCKINLEY AVENUE LLC		
					MORTON GROVE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 9,687	$ 9,687	1
2	V	17	ADMINISTRATIVE	539,304	MR. BELLOWS OWNS 62.5% OF THIS FACILITY		15,976	(523,328)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		5,789	5,789	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,240	1,240	4
5	V	21	CLERICAL		" "		113,960	113,960	5
6	V	24	TRAVEL		" "		9,868	9,868	6
7	V	26	INSURANCE		" "		4,935	4,935	7
8	V	30	DEPRECIATION		" "		3,124	3,124	8
9	V	34	RENT		" "		15,660	15,660	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		6,602	6,602	10
11	V								11
12	V								12
13	V								13
14	Total			$ 539,304			$ 186,841	$ * (352,463)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 576,000	MCKINLEY AVENUE, LLC.		$	$ (576,000)	15
16	V	26	INSURANCE - MORTGAGE		" "		50,260	50,260	16
17	V	30	DEPRECIATION - BLDG/IMPROV		" "		183,502	183,502	17
18	V	30	DEPRECIATION - EQPT		" "		54,000	54,000	18
19	V	32	AMORTIZATION - MTG COST		" "		4,347	4,347	19
20	V	32	INTEREST - MORTGAGE		" "		420,540	420,540	20
21	V	32	INTEREST - OTHER		" "		11,118	11,118	21
22	V	19	ACCOUNTING		" "		6,750	6,750	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 576,000			$ 730,517	$ * 154,517	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMIN.	62.5%	SEE ATTACHED	2.42	10.21	SALARY	15,976	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,976		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	493,454	9	$ 94,929	$ 94,929	50,355	$ 9,687	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	159,981	50,355	15,976	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724		50,355	5,789	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155		50,355	1,240	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338		50,355	19,526	5
6	21	CLERICAL	DIRECT COST	1	1	94,434	94,434	1	94,434	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702		50,355	9,868	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361		50,355	4,935	8
9	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611		50,355	3,124	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459		50,355	15,660	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	493,454	9	64,696		50,355	6,602	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,003,390	$ 349,344		$ 186,841	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - MCKINLEY AVE, LLC.						$	$			$	1
2	GMAC MORTGAGE CORP.		X	MORTGAGE	$39,218.00	07/2002	6,375,000	6,306,801	07/2037	6.6600	420,540	2
3	LOAN COSTS			LOAN COSTS	AMORT-35YRS		152,161	152161-7211			4,347	3
4												4
5												5
	Working Capital											
6												6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	1,712,723	DEMAND	VARIES	107,637	7
8												8
9	TOTAL Facility Related				$39,218.00		$ 7,002,161	$ 8,019,524			$ 532,524	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,002,161	$ 8,019,524			$ 532,524	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 50,260 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	65,688	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	69,633	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,945	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	70,404	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,349	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000	31,866	10
2001	64,976	11
2002	69,633	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-011	NURSING HOME	$ 139,266.24	$ 69,633.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,266.24	$ 69,633.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	119,700	1997	$	1
2					2
3	TOTALS	119,700		$	3

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1997		$ 4,688,282	$ 170,483	27.5	$ 170,483	$	$ 1,186,277	4
5			1997		10,762	391	27.5	391		2,528	5
6			1998		95,000	3,455	27.5	3,455		20,584	6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MCKINLEY AVE, LLC										9
10	OUTDOOR SIGNS			1997	13,284	483	27.5	483		3,119	10
11	REPLACE, REPAIR AND SEAL PAVEMENT			1998	6,754	421	15	450	29	2,475	11
12	REPLACE BLACK VALLEYS			1999	5,875	214	27.5	214		953	12
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS			1999	154,975	5,635	27.5	5,635		25,124	13
14	SPRINKLER SYSTEMS			1999	4,744	173	27.5	173		770	14
15	COURTYARD IMPROVEMENTS			1999	5,975	460	15	398	(62)	1,791	15
16	RESIDENT ROOMS/BATHROOMS - PAINTING			2000	13,710	498	27.5	498		1,724	16
17	FIRE ALARM CONTROL PANEL			2000	6,703	244	27.5	244		843	17
18	REMODELING - ARCHITECT FEE			2000	1,493	115	15	100	(15)	350	18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATIONS			2001	7,382	268	27.5	268		659	19
20	REPLACED 2 YORK ROOFTOP HVAC UNITS			2003	11,340	189	27.5	189		189	20
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS			2003	19,732	329	27.5	329		329	21
22	STENCIL & COAT LANDING DOCK & WALKWAY			2003	4,397	73	27.5	73		73	22
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING			2003	2,000	34	27.4	34		34	23
24	PREPARE & RESURFACE NORTH PARKING LOT			2003	5,120	85	27.5	85		85	24
25											25
26					ADJ TO SL	(48)			48		26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,057,528	$ 183,502		$ 183,502	$	$ 1,247,907	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 307,209	$ 35,534	$ 25,867	$ (9,667)	3-15YRS	$ 99,435	71
72	Current Year Purchases	41,937	22,798	2,097	(20,701)	3-15YRS		72
73	Fully Depreciated Assets	12,990						73
74	RELATED PARTY	540,000	57,124	57,124			297,000	74
75	TOTALS	$ 902,136	$ 115,456	$ 85,088	$ (30,368)		$ 396,435	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,959,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 298,958	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 268,590	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30,368)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,644,342	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 21,714 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	2002 DODGE PICKUP	$ 281.46	$ 3,378	17
18					18
19					19
20					20
21	TOTAL		$ 281.46	$ 3,378	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 212,309	$		$ 212,309	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			45,633			45,633	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			232,860			232,860	4
5	Physician Care		visits							5
6	Dental Care		visits			679			679	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				149,739		149,739	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS, LAB, I.V. THERAPY Other (specify):	39-2					23,307		23,307	13
14	TOTAL			$		$ 491,481	$ 173,046		$ 664,527	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 441,572	$ 520,159	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,992)	983,946	983,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,253	84,725	6
7	Other Prepaid Expenses	25,890	25,890	7
8	Accounts Receivable (owners or related parties)	169,522	10,000	8
9	Other(specify): ESCROW DEPOSITS		218,195	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,649,183	$ 1,842,915	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,079,646	3,079,646	11
12	Long-Term Investments	1,351	1,351	12
13	Land		827,400	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		274,246	15
16	Equipment, at Historical Cost	349,146	889,146	16
17	Accumulated Depreciation (book methods)	(268,901)	(2,033,356)	17
18	Deferred Charges	833	145,783	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		801,211	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,162,075	$ 8,768,709	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,811,258	$ 10,611,624	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,724	$ 155,650	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,041	64,041	28
29	Short-Term Notes Payable	1,400,000	1,400,000	29
30	Accrued Salaries Payable	27,077	27,077	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,195	5,195	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70,404	32
33	Accrued Interest Payable		39,317	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	3,543	3,543	36
37	DUE TO RELATED PARTY	41,063	188,011	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,680,643	$ 1,953,238	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,565,775		39
40	Mortgage Payable		6,306,801	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,565,775	$ 6,306,801	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,246,418	$ 8,260,039	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,564,840	$ 2,351,585	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,811,258	$ 10,611,624	48

*(See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 849,574	1
2	Restatements (describe):		2
3	DEPRECIATION ADJ.	(9,323)	3
4	ROUNDING ADJ.	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 840,255	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	774,585	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 724,585	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,564,840	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,783,548	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,783,548	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,040	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,040	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82,797	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,797	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	2,466	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,466	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,869,851	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,218	31
32	Health Care	1,854,149	32
33	General Administration	1,606,709	33
	B. Capital Expense		
34	Ownership	833,538	34
	C. Ancillary Expense		
35	Special Cost Centers	664,527	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,095,266	40
41	**Income before Income Taxes (line 30 minus line 40)****	774,585	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 774,585	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,046	2,086	$ 54,225	$ 25.99	1
2	Assistant Director of Nursing	2,038	2,086	42,490	20.37	2
3	Registered Nurses	11,532	11,896	222,704	18.72	3
4	Licensed Practical Nurses	25,756	27,213	399,523	14.68	4
5	Nurse Aides & Orderlies	70,053	73,785	688,387	9.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,697	6,113	82,066	13.42	8
9	Activity Director	3,722	3,981	62,958	15.81	9
10	Activity Assistants	5,460	5,812	42,770	7.36	10
11	Social Service Workers	2,255	2,483	27,245	10.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,590	13,493	132,790	9.84	14
15	Cook Helpers/Assistants	13,934	14,169	92,834	6.55	15
16	Dishwashers					16
17	Maintenance Workers	2,939	3,117	48,824	15.66	17
18	Housekeepers	18,952	20,375	178,257	8.75	18
19	Laundry	11,182	11,755	90,676	7.71	19
20	Administrator	1,966	2,086	63,693	30.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,518	8,931	116,415	13.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,263	3,399	36,662	10.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,903	212,780	$ 2,382,519 *	$ 11.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	216	$ 10,712	1-3	35
36	Medical Director	120	28,920	9-3	36
37	Medical Records Consultant	12	945	10-3	37
38	Nurse Consultant	338	13,943	10-3	38
39	Pharmacist Consultant	216	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,852	11-3	44
45	Social Service Consultant	48	2,852	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	998	$ 61,424		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TOM MULLINS	ADMIN		$ 63,693
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,693

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 539,304
TOTAL (agree to Schedule V, line 17, col. 3)		$ 539,304
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		152,399
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 152,399

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 61,972
Unemployment Compensation Insurance		27,622
FICA Taxes		177,901
Employee Health Insurance		152,615
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,178
EMPLOYEE PHYSICAL EXAMS		5,368
PENSION/PROFIT SHARING PLANS		10,677
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 438,333

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,861
Health Care Worker Background Check	348
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	31,756
TRUST/FRANCHISE/CONTRIB/ETC	20
LICENSES & PERMITS	1,021
DUES & SUBSCRIPTIONS	16,030
MGMT CO ALLOCATION	1,240
TRUST/FRANCHISE/CONTRIB/ETC	(20)
Less: Public Relations Expense	(14,508)
Non-allowable advertising	(8,002)
Yellow page advertising	(9,246)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,500

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,360
RELATED PARTY	9,868
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,228

**See instructions.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	06/2000	$ 2,965	3	$ 494	$ 988	$ 988	$ 495	$	$	$	$	$
2	PAINTING/DECORATIN	06/2001	9,907	3		1,652	3,302	3,302	1,651				
3	PAINTING/DECORATIN	06/2002	2,840	3			473	947	947	473			
4	PAINTING/DECORATIN	06/2003	9,437	3				1,572	3,146	3,146	1,573		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 25,149		$ 494	$ 2,640	$ 4,763	$ 6,316	$ 5,744	$ 3,619	$ 1,573	$	$

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. HEALTHCARE ASSOC. $ 8820**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,002** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees